

: RUNHUV · & RPSHQVDWLRQ \$FFL

EMPLOYEE SECTION ±Complete, sign and give to supervisor immediately. Failure to report injury may delay benefits.

Name: _____ (Last, First, Middle) DOB: _____ M F S W
(Gender) (Marital Status)

UIN: _____ Hire Date: _____ Home Address: _____
(Street, City, Zip Code)

Home Phone: () _____ Department: _____

Work Phone: () _____ Faculty/Staff Hourly Other Time you began work on date of injury: _____
(Employee Type)

Job Title: _____
:

Injuries Sustained: _____
(part of body-left/right)

Name of witness(es): _____

Is medical treatment needed? Yes No
(You must select a physician from the attached panel physician form)

\$UH \RX HQUROOHG LQ WKH VW Yes No

Are you enrolled in the Virginia Sickness & Disability Program? Yes No

I certify that(e)4.005003 ()-o70 05 (m)5 2 (8 (oc)-6.007 (20 (m)-176.007 a)12 ()-5.005 (ron)(t)-5 ((05 (p(h)4.005 (e)4oc)-6.007v(e)4.005id)176.007 e(h)4.

: RUNHUV · & RPSHQVDWLRQ 3DQHO 3KV

7KH 9LUJLQLD : RUNHUV · & RPSHQVDWLRQ 3DQHO 3KV Panel of at least three physicians. You must select a physician from this Panel to treat your work-related

injury. Appointments are not necessary. **If you do not use one of these physicians for your work -**

related injury, you may be responsible for the cost of medical care .

Please select a physician from this Panel, complete and sign this form and return it to Human

5HVRXUFHV DORQJ ZLWK WKH FRPSHWHG : RUNHUV · & RPSHQVDWLRQ

Dr. Anthony Russo

9 HORFLW \ 8 U J H Q W & D U
1326 E. Little Creek Road
Norfolk, VA 23518
757- -

Dr. Maulin Desai

Patient First
3432 Holland Road
Virginia Beach, VA 23452
757-468-1855

Dr. 0 L F K D H O % D G G H U

, 2 0 H G L F D O & H Q W H U
7 7 K L P E O H 6 K R D O V % O Y G
Newport News, VA 2360
757- -

By signing this form, I release all medical information to Managed Care Innovations WKH V W D W

Z RUNHUV · FRPSHQVDWLRQ FAIDIP Be Considered Confidential and

XVHG RQO \ LQ WKH PDWWHU RI WKH. Z RUNHUV · FRPSHQVDWLRQ

I have been presented with a panel of at least three physicians and have selected

Dr. _____ to provide me with medical care for my work-related injury.

Signed: _____ Date: _____
NAME

Printed: _____ Date of Injury: _____
NAME

, P S R U W D Q W , Q I R U P D W L R Q D E F

Compensation

Medical expenses for work related injuries are payable, provided a claim has been filed within the required time frame and the insurance carrier accepts your claim and determines the accident/injury falls within the parameters of the Workers' Compensation Act and in the course of employment. If your panel physician certifies that you are unable to work at all, and the claim is determined to be